



## Complete Summary

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### GUIDELINE TITLE

Presentations of lung cancer with special treatment considerations.

### BIBLIOGRAPHIC SOURCE(S)

Detterbeck FC, Jones DR, Kernstine KH, Naunheim KS. Presentations of lung cancer with special treatment considerations. Chest 2003 Jan; 123(1 Suppl):244S-58S. [56 references] [PubMed](#)

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## SCOPE

### DISEASE/CONDITION(S)

Particular forms of non-small cell lung cancer that require special considerations, including Pancoast tumors, T4N0,1M0 tumors, satellite nodules in the same lobe, synchronous and metachronous multiple primary lung cancers (MPLC), and solitary metastases.

### GUIDELINE CATEGORY

Diagnosis  
Treatment

### CLINICAL SPECIALTY

Oncology  
Pulmonary Medicine  
Radiation Oncology  
Radiology  
Thoracic Surgery

## INTENDED USERS

Physicians

## GUIDELINE OBJECTIVE(S)

To provide clinically relevant, evidence-based guidelines for lung cancers with special treatment considerations

## TARGET POPULATION

Patients with particular forms of non-small cell lung cancer that require special considerations. These include patients with Pancoast tumors, T4N0,1M0 tumors, satellite nodules in the same lobe, synchronous and metachronous multiple primary lung cancers (MPLC), and solitary metastases.

## INTERVENTIONS AND PRACTICES CONSIDERED

### Treatment

#### Pancoast Tumors

##### Workup

1. Tissue diagnosis prior to therapy
2. Thoracic surgeon evaluation if no evidence of mediastinal node involvement
3. Evaluation for lung resection
  - Magnetic resonance imaging (MRI) of thoracic inlet and brachial plexus
  - Computed tomography (CT) of the chest
  - Cervical mediastinoscopy

##### Treatment

1. Preoperative chemoradiotherapy or radiotherapy
2. Complete resection (lobectomy including removal of involved chest wall structures); contraindicated if involvement of mediastinal nodes
3. Combination chemotherapy and radiotherapy (good performance status and unresectable but nonmetastatic tumors)

#### Therapy Considered but Not Recommended

##### Postoperative radiotherapy

#### T4N0,1M0 Tumors

##### Workup

1. Imaging studies prior to surgical resection
2. Careful selection of candidates for tumor resection
3. Mediastinoscopy prior to surgery

## Treatment

1. Resection
2. Chemoradiotherapy alone or prior to resection

## Satellite Nodules in the Same Lobe

### Workup

Distant organ scanning as dictated by the primary lung cancer (confirm mediastinal node status)

## Treatment

### Lobectomy

## Synchronous Second Primary Lung Cancer

### Workup

1. Investigation for extrathoracic primary cancer and distant metastases in suspected patients
2. Confirm absence of mediastinal node involvement

## Treatment

1. Resection of both lung cancers (negative metastases or mediastinal lymph node involvement)
2. Resection of each lesion in patients discovered to have a second cancer in a different lobe intraoperatively (adequate pulmonary reserve and no N2 nodal involvement)

## Metachronous Second Primary Lung Cancer

### Workup

Investigation for distant metastases

## Treatment

Resection (negative metastases or mediastinal lymph node involvement)

## Isolated Brain Metastasis

### Workup

1. Imaging studies to confirm absence of distant metastases
2. Mediastinoscopy to rule out N2,3 involvement prior to resection (patients with synchronous presentation and resectable primary lung cancer)

## Treatment

Isolated brain metastasis resection or radiosurgical ablation (no sites of metastases and metachronous or synchronous resectable N0,1 presentation)

Therapies Considered but Evidence is Conflicting and/or Insufficient

1. Adjuvant chemotherapy for patients who have undergone curative brain resection and resection of the primary tumor
2. Brain radiotherapy for patients who have undergone curative brain resection

## Isolated Adrenal Metastasis

### Workup

1. Imaging studies to confirm absence of distant metastases
2. Mediastinoscopy to rule out N2,3 involvement prior to resection (patients with synchronous presentation and resectable primary lung cancer)

## Treatment

Isolated adrenal metastasis resection (no sites of metastases and metachronous or synchronous resectable N0,1 presentation)

## MAJOR OUTCOMES CONSIDERED

- 5-year survival
- Palliation of pain
- Operative mortality

## METHODOLOGY

### METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)  
Searches of Electronic Databases

### DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

#### Overview

As a first step in identifying the evidence for each topic, the guideline developers sought existing evidence syntheses including guidelines, systematic reviews, and meta-analyses. They searched computerized bibliographic databases including MEDLINE, Cancerlit, CINAHL and HealthStar, the Cochrane Collaboration Database of Abstracts of Reviews of Effectiveness, the National Guideline Clearinghouse, and the National Cancer Institute Physician Data Query database. Computerized searches through July 2001 used the MeSH terms lung neoplasms (exploded) and bronchial neoplasms or text searches for lung cancer combined with review articles, practice guidelines, guidelines, and meta-analyses. They also searched

and included studies from the reference lists of review articles, and queried experts in the field. An international search was conducted of Web sites of provider organizations that were likely to have developed guidelines. Abstracts of candidate English language articles were reviewed by two physicians (one with methodological expertise and one with content area expertise) and a subset was selected for review in full text. Full-text articles were reviewed again by two physicians to determine whether they were original publications of a synthesis and were pertinent to at least one of the topics of the guideline. Articles described as practice guidelines, systematic reviews, or meta-analyses were included, as were review articles that included a "Methods" section. Included articles were classified according to topic.

#### Strategy Specific for Special Treatment Issues in Non-small Cell Lung Cancer

A formal meta-analysis was not available for any of the particular forms of non-small cell lung cancer (NSCLC) that are the subject of this chapter of the original guideline, and resources did not permit the American College of Chest Physicians (ACCP) to conduct such an analysis independently. Clinical guidelines from other organizations were available only with regard to Pancoast tumors. These involved primarily consensus opinion statements, however, a systematic review of literature in each of these areas was available, published in the year 2001. The recommendations rely heavily on the data from this review.

#### NUMBER OF SOURCE DOCUMENTS

Not stated

#### METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus  
Weighting According to a Rating Scheme (Scheme Given)

#### RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The United States Preventive Services Task Force (USPSTF) scheme offers general guidelines to assign one of the following grades of evidence: good, fair, or poor. In general, good evidence included prospective, controlled, randomized clinical trials, and poor evidence included case series and clinical experience. Trials with fair quality of evidence, for instance, historically controlled trials or retrospective analyses, were somewhere in between. In addition to the strength of the study design, however, study quality also was considered. The United States Preventive Services Task Force approach considers well-recognized criteria in rating the quality of individual studies for a variety of different types of study design (e.g., diagnostic accuracy studies and case-control studies). The thresholds for distinguishing good vs fair and fair vs poor evidence are not explicit but are left to the judgment of panelists, reviewers, and members of the executive committee.

#### Assessment of the Scope and Quality of Clinical Practice Guidelines

Clinical practice guidelines identified from the systematic search were evaluated by at least four reviewers using the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument.

## METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

## DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

## METHODS USED TO FORMULATE THE RECOMMENDATIONS

Informal Consensus

## DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Each writing committee received a comprehensive list of existing systematic reviews and meta-analyses as well as guidelines published by other groups. In addition, for five key topics (prevention, screening, diagnosis, and staging [invasive and noninvasive]), new systematic reviews were undertaken (see "Description of Methods Used to Collect the Evidence" and "Description of Methods Used to Analyze the Evidence" fields). For all other topics, writing committees were responsible for identifying and interpreting studies that were not otherwise covered in existing syntheses or guidelines.

The guidelines developed by the writing committee were distributed to the entire expert panel, and comments were solicited in advance of a meeting. During the meeting, proposed recommendations were reviewed, discussed, and voted on by the entire panel. Approval required consensus, which was defined as an overwhelming majority approval. Differences of opinion were accommodated by revising the proposed recommendation, the rationale, or the grade until consensus could be reached. The evidence supporting each recommendation was summarized, and recommendations were graded as described. The assessments of level of evidence, net benefit, and grade of recommendation were reviewed by the executive committee.

## Values

The panel considered data on functional status, quality and length of life, tolerability of treatment, and relief of symptoms in formulating guideline recommendations. Cost was not explicitly considered in the guideline development process. Data on these outcomes were informally weighted, without the use of explicit decision analysis or other modeling. The values placed on types of outcomes varied with clinical scenarios. For example, in some situations they considered life expectancy, such as the effects of early detection. In other situations they weighed quality of life more heavily, such as in palliative care and in interpreting small increases in life expectancy with chemotherapy for stage IV disease.

## RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The guideline developer's grading scheme is a modification of the United States Preventive Services Task Force (USPSTF) grades to allow recommendations for a service when (1) evidence is poor, (2) the assessment of the net benefit is moderate to high, and (3) there is consensus among the expert panel to recommend it. This change was necessary because, unlike preventive services (i.e., the routine offering of tests or treatments to well people) in which the burden of proof is high, clinical decisions about the treatment of patients with lung cancer often must be based on an interpretation of the available evidence, even if it is of poor quality. This adaptation distinguished between interventions with poor evidence for which there is consensus (grade C) and interventions with poor evidence for which there is not consensus (grade I).

### Grades of Recommendations and Estimates of Net Benefit

The grade of the strength of recommendations is based on both the quality of the evidence and the net benefit of the service (i.e., test, procedure, etc).

**Grade A** The panel strongly recommends that clinicians routinely provide [the service] to eligible patients. An "A" recommendation indicates good evidence that [the service] improves important health outcomes and that benefits substantially outweigh harms.

**Grade B** The panel recommends that clinicians routinely provide [the service] to eligible patients. A "B" recommendation indicates at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.

**Grade C** The panel recommends that clinicians routinely provide [the service] to eligible patients. A "C" recommendation indicates that there was consensus among the panel to recommend [the service] but that the evidence that [the service] is effective is lacking, of poor quality, or conflicting, or the balance of benefits and harms cannot be reliably determined from available evidence.

**Grade D** The panel recommends against clinicians routinely providing [the service]. A "D" recommendation indicates at least fair evidence that [the service] is ineffective or that harm outweighs benefit.

**Grade I** The panel concludes that the evidence is insufficient to recommend for or against [the service]. An "I" recommendation indicates that evidence that [the service] is effective is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined, and that the panel lacked a consensus to recommend it.

### Net Benefit

The levels of net benefit are based on clinical assessment. Estimated net benefit may be downgraded based on uncertainty in estimates of benefits and harms.

**Substantial Benefit:** Benefit greatly outweighs harm

Moderate Benefit: Benefit outweighs harm

Small/weak Benefit: Benefit outweighs harm to a minimally clinically important degree

None/negative Benefit: Harms equal or outweigh benefit, less than clinically important

## COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

## METHOD OF GUIDELINE VALIDATION

Peer Review

## DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The original guideline document on special treatment issues was reviewed by three independent reviewers, and further changes were made. The revised document and recommendations were further reviewed by the entire American College of Chest Physicians (ACCP) Guidelines committee to assure that it met the requirements of a balanced, accurate, and generally acceptable representation of the issues with regard to the particular forms of non-small cell lung cancer (NSCLC).

After extensive review within the expert panel and executive committee, the guidelines were reviewed and approved by the American College of Chest Physicians Health and Science Policy Committee and then by the American College of Chest Physicians Board of Regents.

## RECOMMENDATIONS

### MAJOR RECOMMENDATIONS

Each recommendation is rated based on the levels of evidence (good, fair, poor), net benefit (substantial, moderate, small/weak, none/negative), and the grades of the recommendations (A, B, C, D, I). Definitions are presented at the end of the "Major Recommendations" field.

#### Pancoast Tumors

1. For patients with a Pancoast tumor, a tissue diagnosis should be obtained prior to the initiation of therapy. Level of evidence, poor; benefit, substantial; grade of recommendation, C
2. Patients with a Pancoast tumor without evidence of mediastinal node involvement or distant metastases should be evaluated by an experienced thoracic surgeon for potential resection. Level of evidence, fair; benefit, substantial; grade of recommendation, B

3. Patients with a Pancoast tumor being considered for resection should undergo evaluation with a magnetic resonance imaging (MRI) of the thoracic inlet and brachial plexus, in addition to a computed tomography (CT) of the chest. Level of evidence, fair; benefit, substantial; grade of recommendation, B
4. Resection of patients with a Pancoast tumor with involvement of the subclavian vessels or the vertebral column should not be routinely undertaken (outside of specialized centers). Level of evidence, poor; benefit, moderate; grade of recommendation, D
5. Patients with a Pancoast tumor being considered for curative resection should undergo a cervical mediastinoscopy. Involvement of mediastinal nodes represents a contraindication to resection. Level of evidence, good; benefit, substantial; grade of recommendation, A
6. Patients with a potentially resectable, nonmetastatic Pancoast tumor (and good performance status) should undergo preoperative chemoradiotherapy prior to resection. A reasonable alternative for such patients is preoperative radiotherapy. Level of evidence, fair; benefit, moderate; grade of recommendation, B
7. At the time of resection of a Pancoast tumor, every effort should be made to achieve a complete resection. Level of evidence, good; benefit, substantial; grade of recommendation, A
8. Resection of a Pancoast tumor should consist of a lobectomy (instead of a wedge), as well as removal of the involved chest wall structures. Level of evidence, fair; benefit, moderate; grade of recommendation, B
9. For patients with a Pancoast tumor, postoperative radiotherapy is not recommended, either in completely or incompletely resected patients, because of lack of a demonstrated survival benefit. Level of evidence, poor; benefit, none; grade of recommendation, D
10. Patients with a good performance status and an unresectable but nonmetastatic Pancoast tumor should be considered for combination chemotherapy and radiotherapy with intent to cure. Level of evidence, poor; benefit, moderate; grade of recommendation, C
11. Palliative radiotherapy should be considered in patients who are not candidates for treatment with curative intent (i.e., surgery, chemoradiotherapy etc.). Level of evidence, fair; benefit, moderate; grade of recommendation, B

#### T4N0,1M0 Tumors

12. Patients with a clinical T4N0,1M0 non-small cell lung cancer (NSCLC) should be carefully evaluated (with imaging studies) for distant metastatic disease prior to considering surgical resection. Level of evidence, fair; benefit, substantial; grade of recommendation, B
13. Resection of T4N0,1M0 tumors in selected patients may result in better survival than chemoradiotherapy without resection. Level of evidence, poor; benefit, moderate; grade of recommendation, C
14. Mediastinoscopy should be done prior to surgical resection of patients with clinical T4N0,1M0 tumors. Level of evidence, fair; benefit, substantial; grade of recommendation, B

#### Satellite Nodules of Cancer in the Same Lobe

15. No further diagnostic workup of a satellite nodule is needed in patients with suspected or proven lung cancer and a satellite nodule within the same lobe. Level of evidence, fair; benefit, moderate; grade of recommendation, B
16. For patients with a satellite lesion within the same lobe as a suspected or proven primary lung cancer, distant organ scanning and confirmation of the mediastinal node status should be carried out as dictated by the primary lung cancer alone, and not modified due to the presence of the satellite lesion. Level of evidence, poor; benefit, small; grade of recommendation, C
17. For patients with NSCLC and a satellite focus of cancer within the same lobe, resection via a lobectomy is the preferred treatment. Level of evidence, fair; benefit, substantial; grade of recommendation, B

#### Synchronous Second Primary Lung Cancer

18. Patients suspected of having two synchronous primary lung cancers should have a thoughtful search for an extrathoracic primary cancer to rule out the possibility that both of the lung lesions represent metastases from an extrathoracic primary. Level of evidence, poor; benefit, substantial; grade of recommendation, C
19. For patients suspected of having two synchronous primary lung cancers, a careful and thorough search for distant metastases should be performed. Level of evidence, poor; benefit, substantial; grade of recommendation, C
20. For patients suspected of having two synchronous primary lung cancers, the absence of mediastinal node involvement should be confirmed (usually via mediastinoscopy) prior to resection. Level of evidence, poor; benefit, substantial; grade of recommendation, C
21. For patients with two synchronous primary lung cancers, resection of both lung cancers is reasonable provided a careful search for distant metastases or mediastinal lymph node involvement has been carried out and is negative. Level of evidence, poor; benefit, moderate; grade of recommendation, C
22. If a patient (not suspected of having a second focus of cancer) is discovered intraoperatively to have a second cancer in a different lobe, it is recommended that a resection of each lesion is undertaken, provided the patient has adequate pulmonary reserve and there is no N2 nodal involvement. Level of evidence, poor; benefit, moderate; grade of recommendation, C

#### Metachronous Second Primary Lung Cancer

23. A careful and thorough search for distant metastases should be performed in patients suspected of having metachronous second primary lung cancers. Level of evidence, poor; benefit, substantial; grade of recommendation, C
24. Resection of a metachronous second primary lung cancer is reasonable provided a careful search for other distant metastases or mediastinal lymph node involvement has been carried out and is negative. Level of evidence, poor; benefit, moderate; grade of recommendation, C

#### Isolated Brain Metastasis

25. Patients with an isolated brain metastasis from NSCLC should be considered for a curative approach. Level of evidence, poor; benefit, substantial; grade of recommendation, C
26. For patients with an isolated brain metastasis from NSCLC who are being considered for a curative approach, a careful search for other distant metastases should be carried out with imaging tests. Level of evidence, poor; benefit, substantial; grade of recommendation, C
27. For patients with a synchronous presentation of isolated brain metastases and a respectable primary lung cancer, mediastinoscopy should be done to rule out N2,3 involvement prior to curative resection. Level of evidence, poor; benefit, moderate; grade of recommendation, C
28. For patients with no other sites of metastases and a synchronous resectable N0,1 primary NSCLC, resection or radiosurgical ablation of an isolated brain metastasis should be undertaken (as well as resection of the primary tumor). Level of evidence, fair; benefit, substantial; grade of recommendation, B
29. For patients with no other sites of metastases and a previously completely resected primary NSCLC (metachronous presentation), resection or radiosurgical ablation of an isolated brain metastasis should be undertaken. Level of evidence, fair; benefit, substantial; grade of recommendation, B
30. For patients who have undergone a curative resection of an isolated brain metastasis, adjuvant whole brain radiotherapy is reasonable, although there is conflicting and insufficient data regarding a benefit with respect to survival or the rate of recurrent brain metastases. Level of evidence, poor; benefit, unclear; grade of recommendation, I
31. For patients who have undergone a curative resection of an isolated brain metastasis (and resection of the primary tumor), adjuvant chemotherapy can be neither recommended nor recommended against because of insufficient data regarding this issue. Level of evidence, poor; benefit, unclear; grade of recommendation, I

#### Isolated Adrenal Metastasis

32. Patients with an isolated adrenal metastasis from NSCLC should be considered for a curative approach. Level of evidence, poor; benefit, substantial; grade of recommendation, C
33. For patients with an isolated adrenal metastasis being considered for curative therapy, a careful search for other distant metastases should be carried out with imaging tests. Level of evidence, poor; benefit, substantial; grade of recommendation, C
34. For patients with a synchronous presentation of an isolated adrenal metastasis and a resectable primary lung cancer, mediastinoscopy should be done to rule out N2,3 involvement prior to resection. Level of evidence, poor; benefit, substantial; grade of recommendation, C
35. In carefully selected patients with no other sites of metastases and a synchronous resectable N0,1 primary NSCLC, resection of an isolated adrenal metastasis from NSCLC should be undertaken (as well as resection of the primary tumor). Level of evidence, poor; benefit, moderate; grade of recommendation, C
36. For patients with no other sites of metastases and a previously completely resected primary NSCLC (metachronous presentation), resection of an

isolated adrenal metastasis should be undertaken. Level of evidence, poor; benefit, moderate; grade of recommendation, C

### Definitions:

#### Levels of Evidence

In general, good evidence included prospective, controlled, randomized clinical trials, and poor evidence included case series and clinical experience. Trials with fair quality of evidence, for instance, historically controlled trials or retrospective analyses, were somewhere in between.

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Small/weak Benefit: Benefit outweighs harm to a minimally clinically important degree

None/negative Benefit: Harms equal or outweigh benefit, less than clinically important

#### CLINICAL ALGORITHM(S)

None provided

### EVIDENCE SUPPORTING THE RECOMMENDATIONS

#### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

### BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

#### POTENTIAL BENEFITS

These guideline recommendations may assist physicians in achieving the best possible outcomes for their patients, given the knowledge and capabilities at this time.

#### POTENTIAL HARMS

Surgical resections carry the risk of operative mortality.

### CONTRAINDICATIONS

#### CONTRAINDICATIONS

N2,3 lymph node involvement in patients with Pancoast tumors is a major negative prognostic factor and should generally be considered a contraindication to surgery.

### QUALIFYING STATEMENTS

#### QUALIFYING STATEMENTS

The scope of this project did not allow inclusion of special histologic types of lung cancer, such as typical and atypical carcinoid tumors, mucoepidermoid tumors, or bronchioloalveolar carcinomas.

### IMPLEMENTATION OF THE GUIDELINE

#### DESCRIPTION OF IMPLEMENTATION STRATEGY

1. The American College of Chest Physicians (ACCP) is developing a set of PowerPoint slide presentations for physicians to download and use for physician and allied health practitioners education programs.
2. The ACCP is developing a Quick Reference Guide (QRG) in print and PDA formats for easy reference.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

End of Life Care  
Living with Illness

### IOM DOMAIN

Effectiveness

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

Detterbeck FC, Jones DR, Kernstine KH, Naunheim KS. Presentations of lung cancer with special treatment considerations. Chest 2003 Jan; 123(1 Suppl):244S-58S. [56 references] [PubMed](#)

### ADAPTATION

Not applicable: Guideline was not adapted from another source.

### DATE RELEASED

2003 Jan

### GUIDELINE DEVELOPER(S)

American College of Chest Physicians - Medical Specialty Society

### GUIDELINE DEVELOPER COMMENT

The guideline development panel was composed of members and nonmembers of the American College of Chest Physicians (ACCP) who were known to have expertise in various areas of lung cancer management and care, representing multiple specialties from the following 13 national and international medical associations:

- Alliance for Lung Cancer Advocacy, Support, and Education (a patient support group)
- American Association for Bronchology

- American Cancer Society
- American College of Physicians
- American College of Surgeons Oncology Group
- American Society of Clinical Oncology
- American Society for Therapeutic Radiology and Oncology
- American Thoracic Society
- Association of Community Cancer Centers
- Canadian Thoracic Society
- National Comprehensive Cancer Network
- Oncology Nurses Society
- Society of Thoracic Surgeons

The specialties included pulmonary/respiratory medicine, critical care, medical oncology, thoracic surgery, radiation oncology, epidemiology, law, and medical ethics.

#### SOURCE(S) OF FUNDING

Funding for both the evidence reviews and guideline development was provided through an unrestricted educational grant from Bristol-Myers Squibb, which had no other role in the evidence review or guideline development process or content.

#### GUIDELINE COMMITTEE

American College of Chest Physicians (ACCP) Expert Panel on Lung Cancer Guidelines

#### COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Primary Authors: Frank C. Detterbeck, MD, FCCP; David R. Jones, MD, FCCP; Kemp H. Kernstine, MD, PhD, FCCP; Keith S. Naunheim, MD, FCCP

#### FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Information about potential conflicts of interest were collected from each member of the expert panel or writing committee at the time of their nomination in accordance with the policy of the American College of Chest Physicians. Information on conflicts of interest for each panelist is listed in the guideline.

#### GUIDELINE STATUS

This is the current release of the guideline.

#### GUIDELINE AVAILABILITY

Electronic copies: Available to subscribers of [Chest - The Cardiopulmonary and Critical Care Journal](#).

Print copies: Available from the American College of Chest Physicians, Products and Registration Division, 3300 Dundee Road, Northbrook IL 60062-2348.

## AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

### Background Articles

- Alberts WM. Lung cancer guidelines. Introduction. Chest 2003 Jan; 123(1 Suppl): 1S-2S
- McCrory DC, Colice GL, Lewis SZ, Alberts WM, Parker S. Overview of methodology for lung cancer evidence review and guideline development. Chest 2003 Jan; 123(1 Suppl): 3S-6S.
- Harpole LH, Kelley MJ, Schreiber G, Toloza EM, Kolimaga J, McCrory DC. Assessment of the scope and quality of clinical practice guidelines in lung cancer. Chest 2003 Jan; 123(1 Suppl): 7S-20S.
- Alberg AJ, Samet JM. Epidemiology of lung cancer. Chest 2003 Jan; 123(1 Suppl): 21S-49S.

Electronic copies: Available to subscribers of [Chest - The Cardiopulmonary and Critical Care Journal](#).

Print copies: Available from the American College of Chest Physicians, Products and Registration Division, 3300 Dundee Road, Northbrook IL 60062-2348.

## PATIENT RESOURCES

None available

## NGC STATUS

This NGC summary was completed by ECRI on September 3, 2003. The information was verified by the guideline developer on October 1, 2003.

## COPYRIGHT STATEMENT

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